WHERE DO WE FIT IN ?

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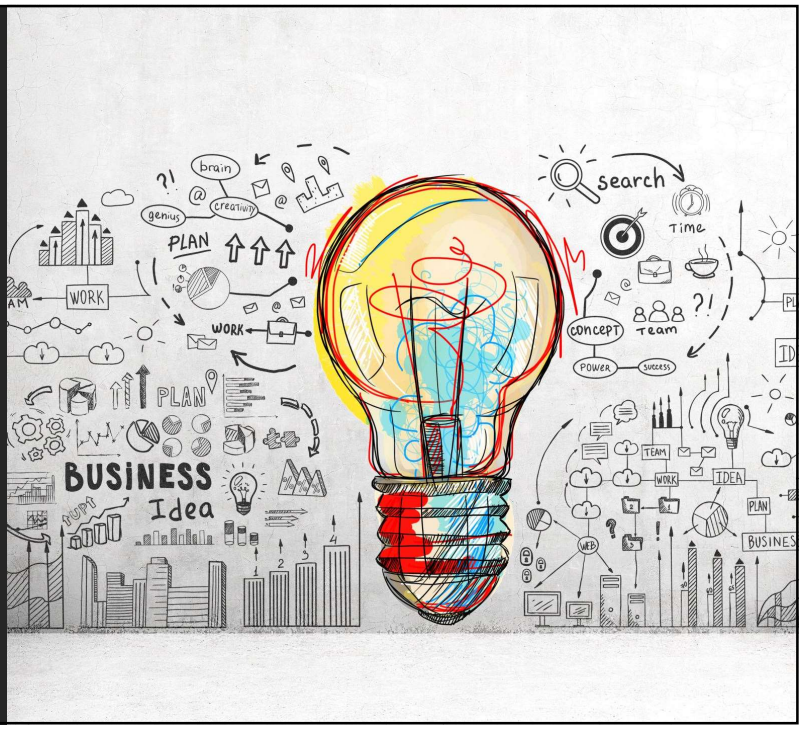

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OVERVIEW ….

- Insurance concerns
- Patient concerns
- Quality of care
- Onset of big brother or EMR
- Where are they going with this ?
- Where does this leave us ?

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LET'S GO BACK TO THE BEGINNING WITH THE ACA

- Great concept of Health Care Reform:
- The 3 major goals of the Patient Protection and the Affordable Care Act (ACA) began earlier ..... But met with Challenges of the constitutionality of the ACA and the outcome .
- 1946: Right to Health-Fundamental to Human Rights was proclaimed in the WHO constitution
- 1948 : Universal Declaration of Human Rights

  (Article 25) UN approved
- 1966 : International Covenant on Economic, Social & Cultural Rights (ICESCR) began

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ICESCR

- ICESCR recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"
- ICESCR has 172 parties globally as of February 2024
- The Right to Health has been incorporated in many other international & regional human rights treatises and many national constitutions
- **NOTE: U.S. President Jimmy Carter signed the ICESCR resolution in 1977 but the U.S. Congress has not yet officially ratified it, hence U.S. is not yet a party to ICESCR, the only industrialized member of the United Nations that has not done so**

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KEY ASPECTS OF THE RIGHT TO HEALTH

- Right to health is an inclusive right
  - Includes access to healthcare plus attention to underlying social and environmental factors that contribute to health (Social Determinants of Health)
- Equal opportunity to all to enjoy the highest attainable level of health
- The right to prevention, treatment and control of diseases
- Concept of essential medicines Defined by the World Health Organization (WHO)

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HEALTH AS A HUMAN RIGHT QUOTATIONS

- *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control"*

United Nations, Universal Declaration on Human Rights, 1948.

- *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition"*

Constitution of the World Health Organization, 1946

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MAJOR CHARACTERISTICS OF THE U.S. HEALTHCARE SYSTEM

- Almost all developed countries have a unitary healthcare system with central government control, funded mostly by taxes and providing universal access to a package of routine and basic health services
- The U.S. has a vast, complex and fragmented multiple healthcare sub-systems with little integration & coordination & no central governing agency
- Congress is able to enact healthcare legislation under Article 1, Section 8, Clause 1 of the Constitution, "---the Congress shall have Power to lay and collect taxes –to provide for the ---general welfare of the United States."
- Difficult to navigate by patients since it is technology driven and requires yearly recertification
- So far only Medicaid is state governed and Medicare is federal

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THE UNINSURED POPULATION IN THE U.S.

- In spite of the size, complexity & expenditures of the U.S. healthcare system, a sizeable portion of the population remains uninsured
- About 17.1% of the nonelderly people in the U.S. were uninsured in the last quarter of 2013
- Reasons for lack of Insurance include:
  - High cost (paying the fine from ACA was cheaper than insurance)
  - Lack of coverage through employer (either not being offered, or not eligible when offered or not able to afford premiums especially for the family)
  - Loss of job (remember majority receive insurance through employer)
  - Self employed
  - Not eligible for public health insurance coverage (Medicaid restrictions FPL)

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PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA), MARCH 2010: GOALS OF ACA

- Expand health insurance coverage
- Improve the quality of care and contain costs
- Regulate the insurance industry for better patient protections against abuse and high cost

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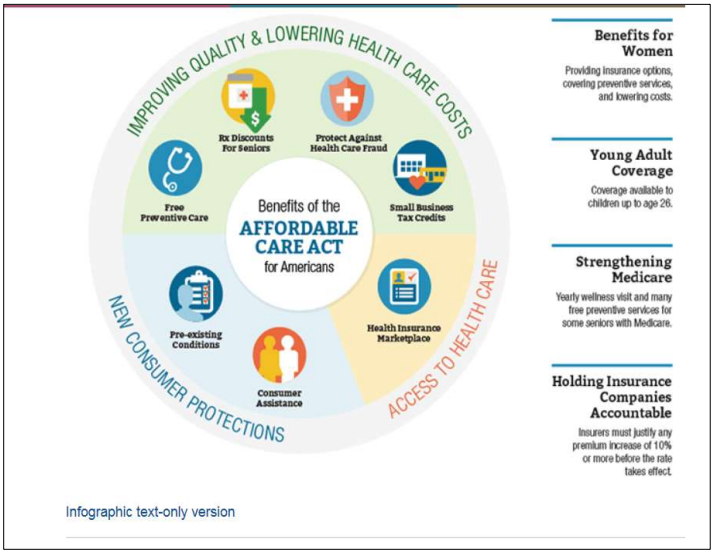
PIPE DREAM

- The ACA failed before it began:
- Fines enacted
- Many young adults still uninsured
- Financially squashed by private sector insurance companies



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DURING CE DISCUSSION OF: SOCIAL DETERMINANTS OF HEALTH

- **Social determinants of health (SDoH)** are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples:
- Safe housing and reliable transportation
- Exposure to racism, discrimination, and violence
- Access to quality education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Exposure to polluted air and water
- Language and literacy skills

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MAJOR CHALLENGES OF HEALTHCARE DELIVERY IN THE U.S.

- Increasing healthcare cost
- Inequities in access
- Inequalities in the quality of care

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WHAT ARE THE CONCERNS…

- Concern that cost containment measures put in place may adversely affect quality of care delivery, hence more attention being given to quality monitoring.
- "Healthcare Quality & Patient Safety
- "Healthcare should heal, not hurt, injure or kill."

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INSTITUTE OF MEDICINE (IOM) DEFINITIONS

- Health care quality : "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."
- Public health : "---fulfilling society's interest in assuring conditions in which people can be healthy."
- *Underscores the breadth of public health & the wide array of social determinants of health*
- *Society's interest denotes improving the health status and living conditions of others is acting in society's own interest*

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WINSLOW'S DEFINITION OF PUBLIC HEALTH (1920)

- "The science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community effort for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and for the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity."

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PROVIDERS NOW NEED TO BE CULTURALLY COMPETENT

- Cultural competence — loosely defined as the ability to understand, appreciate and interact with people from cultures or belief systems different from one's own — has been a key aspect of psychological thinking and practice for some 50 years. It's become such an integral part of the field that it's listed as one of psychology's core competencies. The federal government, too, views it as an important means of helping to eliminate racial, ethnic and socioeconomic disparities in health and mental health care.

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THUS
ANNUAL CULTURAL COMPETENCY TRAINING

- To understand that patients have rights and that translators must be used properly to abhere to these rights
- *it is critical that our providers know how to communicate effectively with our members in the most culturally appropriate way. The New York State Department of Health (DOH) has approved cultural competency training offered by the United States Department of Health and Human Services (HHS) Office of Minority Health education program, Think Cultural Health. The training is online, free, and offers several provider-specific modules.*

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MODELS OF EFFECTIVE PROVIDER-PATIENT COMMUNICATION

- The LEARN model is a mnemonic for a suggested framework for listening, explaining, acknowledging, recommending, and negotiating health information and instructions (Berlin & Fowkes, 1983).
- The BATHE model provides a useful mnemonic for eliciting the psychosocial context of the patient's experience with illness through asking simple questions about background, affect, trouble, handling, and empathy (Stuart & Lieberman, 1993).

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WHY ARE WE DISCUSSING ALL THESE ISSUES… DEATH OF INDIVIDUALIZED CARE

- ACA act changed healthcare
- Activated big brother system … no more provider based care protocols .
- Now EMR or EHR continues monitoring process and will only get worse when doing what we do best…. Individualized treatment .

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EMR / EHR

- Easily accessible records
- Easily accessible issues with QA
- QA becomes QC
- Control is control

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WHAT DOES THIS ALL MEAN

- Individualized care will be QC and altered
- Concepts of QC will change how we practice
- Concept of individual care and control over that care causes providers to worry so much about QA and QC they lose the patient .
- What to do ?

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WHERE DOES THIS LEAVE US ?

- Consider all cash operation and offer receipts for reimbursements ?
- Work within the system and realize you will be judged for your choices ?
- Retire early ?
- Give up and work for someone else ?
- Other options ?

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